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PATHOGENESIS.

The Pathological Anatomy and Pathogenesis of Disseminated Chronic Pneumonia, and of Pulmonary Tubercles. By H. LEBERT, Professor of Clinical Medicine of the University of Breslau.

TRANSLATED BY WALTER HAY, M.D., ASSOCIATE EDITOR CHICAGO MEDICAL JOURNAL.

(Continued from p. 559.)

THE pulmonary tissue around these inflammatory foci is rarely normal in their immediate proximity; most frequently hyperæmia, carification, and diffuse lobular pneumonia may be associated with it temporarily. At other times, the diffuse pneumonia has pursued its ordinary progress, but in place of terminating by resolution, it has passed through in the main all these same phases which have just been described under disseminated chronic pneumonia, which ordinarily is then developed at the same time, and the greater part of the time consecutively in other portions of the same or in the other lung. There is thus presented the intermingling of diffuse and disseminated chronic pneumonia.

The pleura participates almost constantly in chronic pneumonia with scattered force, ordinarily with adhesions, thicken-

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ing rather than with fluid effusion. When these adhesions are solid, old, thick, they produce at once immobility of the corresponding intercostal spaces, and a fibrous transformation propagating itself, step by step, from the surface of the lung into its interior.

It is through these adhesions that the collateral circulation is, in part constituted, supplying the place of the numerous vessels whose disappearance has been occasioned by the chronic pneumonia.

The relation of tubercles with pneumonia has been indicated in a different manner. Some assert that there are almost always tubercles when chronic scattered pneumonia exists; others regard this as consecutive. I have arrived at the opposite conclusion, that disseminated chronic pneumonia exists most frequently alone without tubercles, and when these latter are developed, they are generally of a more recent date, rather consecutive, sequences not consequences of the pneumonia. The greater portion of the cicatrices at the summits of the lungs are of inflammatory, not tuberculous, origin.

As, in general, every prolonged inflammation develops secondary inflammations, so is it with disseminated chronic pneumonias, phlegmasiae which tend to a process of ulceration and necrosis.

Among the frequent localizations of this kind, ulcers of the larynx, the epiglottis, of the vocal cords, and of the arytenoid region should be mentioned. Ulcers of the trachea are rare, and still more so are those of the bronchi, whose mucous surface is ordinarily the seat of chronic inflammation; however, in the smaller bronchi the process of cavernous ulceration may as well originate from the mucous membrane as attack it secondarily.

Further, the pneumonic foci occasion the disappearance of many of the minute bronchial ramifications, whilst other and more voluminous branches dilate, especially in the upper portions of the lungs. The bronchial glands are ordinarily tumified and exhibit sometimes little hyperplastic (tuberculous?) foci, or more extensive yellowish infiltrations.

When many of the bronchial glands are infiltrated and voluminous, they compress the nerves and neighboring vessels, and thus provoke grave complications. I have likewise, also, observed an hypertrophy, simple but considerable and multiple, of these glands in disseminated chronic pneumonia as well as in pulmonary tuberculosis. When the infiltrated bronchial glands suppurate, the abscesses may open into the pericardium, into the vena cava superior, into the bronchi, into the æsophagus, into the lungs, and the pleura. On the other hand, it is not rare to find bronchial glands consisting of desiccated infiltration of stony concretions.

The heart is normal, small, with a tendency to fatty degeneration when the marasmus has attained considerable proportions. The digestive tube is rarely healthy. Gastric and intestinal catarrh and especially ulcers of the small intestine and of the colon, even without any intestinal tubercles whatsoever, occur. The mesenteric glands often exhibit the yellowish infiltration of tubercular appearance as the bronchial glands; stony concretions, likewise, especially are found there; suppuration is here rare. The peritoneum becomes inflamed, especially in the vicinity of intestinal ulcers; here are observed inflammatory granulations much resembling tubercles, which are themselves far from being rare in this serous membrane; there are also found here, especially, voluminous yellowish masses, surrounded with much black pigment, sometimes even with a cortical substance, cellulo-vascular, a true inflammatory product, which in its turn has developed by cellular multiplication these compact or soft masses of a dull yellow color. Inflammatory or tuberculous granulations are found also in the filaments, bridles and false ligaments consecutive to peritonitis. Besides the adhesive and plastic character, besides the complication with true tubercle, there are likewise found serous and sero-purulent fluids. Tubercular peritonitis may exist associated with chronic pneumonia, as well as with pulmonary tubercles, just as a peritonitis, not tubercular, may complicate these two kinds of pulmonary alteration. When profound intestinal alterations exist, the liver is ordinarily fat.

Very small miliary tubercles are here very frequently met with in true pulmonary tuberculization, but very rarely in chronic pneumonia. The same is true of the kidneys and the spleen. These three organs may likewise be the seat of amyloid degeneration, and then the intestinal ulcers may have the same origin. This especially is a very frequent complication, but not a sequel of disseminated chronic pneumonia. Among the cerebral alterations, inflammation of the internal membrane of the ventricles, and acute hydrocephalus are met with in a certain number of cases; tubercular meningitis as well as more voluminous tubercles of the dura mater and of the brain are more frequently consecutive to true tubercle, and sustain scarcely any intimate relation with disseminated chronic pneumonia. In the large tubercular masses of the nervous centres, it is not rare to find a vascular envelope with a connective tissue in process of proliferation, a tissue of a reddish yellow, sometimes semi-transparent, which towards the centre of the tubercles becomes dull, dry, and sometimes exhibits softened portions. The kidneys are rarely diseased in chronic pneumonia, but are sometimes the seat of parenchymatous inflammation. Large tuberculous masses with ulceration are here rare.

Tuberculosis of the mucous surface of the genito-urinary organs has this peculiarity, that it constitutes rather an incrustation of the mucous membrane than a submucous deposit.

The testicle, especially the epididymis, may also be the seat of disseminated inflammation, at a later period confluent with a dull, yellow, dry infiltration rather than with true tubercular granulations.

It may be said that generally disseminated chronic pneumonia is combined much more frequently with secondary inflammation than with tubercles of different organs; but if in the lungs even tubercles co-exist with disseminated chronic pneumonia, they are much rather its sequence than its cause. Tubercular alterations of other organs may in their turn occasion in the lungs pneumonia foci, either disseminated or confluent. Then, indubitable tubercles of other organs do not

permit the decision *a priori*, that the accompanying pulmonary alterations are on that account of a tuberculous nature.

Acute tuberculization of the lungs, and acute disseminated pneumonia.—It is only in these acute, or to speak more correctly, subacute affections, that tubercles predominate greatly. I will even add, that very often in disseminated chronic pneumonia, the progress becomes subacute when tubercles have been superadded. Here, then, is the best moment for us to explain what we understand by true tubercles.

The true tubercle is a granulation composed of a cellular proliferation resembling in all respects an inflammatory non-suppurative hyperplasia of connective tissue.

These cellular elements are incompletely developed, surrounded by a solid or gelatiniform intercellular substance; their size varies from one two-hundredth to the one one-hundred and twentieth of a millimetre; their contours are irregular; they exhibit but rarely a distinct nucleus which appears ordinarily closely surrounded with cellular membrane, to such a degree that the membrane of the cell and that of the nucleus form but one body, so to speak. These are the terms in which, since 1844, I have described the cellular element of tubercle, ascribing to the almost solid intercellular substance, in complete development, and I might add cellular aplasia, which causes the granular infiltration to give to the centre of the granulation, at first, and afterwards to the whole of it, a dull yellowish aspect; moreover, there are found sometimes, with these ordinary elements of tubercle, cells more voluminous enclosing these same corpuscles, which I have seen likewise developed in epithelial cells; moreover, I have, since this date, described, as often surrounding true tubercle, granular epithelial cells and pus-cells. I still to-day maintain this to be the correct description of true tubercle. M. L. Meyer,* in a work generally much valued, published about three years ago, describes tubercles in an identical manner twenty years after me. I quote the following passage from his work in

* 1 Virchow's Arch., vol. XXX., p. 62, 1864.

order to enlighten those who have thought proper to attack my description, and of whom several have burlesqued it, in a manner very little in harmony with the serious spirit of my work :

" The characteristic element of the tubercular focus, says M. Meyer, consists in little cells closely juxtaposed, with opaque margins, with simple nuclei as their principal and sole contents, seeing that this nucleus is ordinarily embraced to such a degree by the cellular membrane that the whole cells might be taken for a nucleus. These cells are of unequal size, smaller than those of pus, ordinarily of the size of blood globule, rarely altogether round, etc. Moreover, there are found multinuclear cells belonging in the vicinity, corresponding to an anterior phase of the development, true mother-cells of the little tubercle cells. I am, moreover, satisfied that even those who have attacked my observations have figured within a slight shade, the elements of tubercle as I have. In the last No. of my great work on Pathological Anatomy (1861), I described and figured the development of tubercle as a cellular proliferation of connective tissue.

" In order to show that, from the beginning, in spite of the inferiority of the methods then attainable, I have separated the surrounding inflammatory products from pulmonary tubercle, I should quote, amongst others, the eighteenth aphorism of the conclusion of my work, in the Archives of Müller, of 1844. There is sometimes found around tubercle a particular form of chronic inflammation, with yellow hepatization, of increased consistency. The tissue of the pulmonary vesicles, of the minute bronchial tubes, of the interstitial tissue, is found filled with coagulated fibrine, with fibres of new formation, with granular epithelial cells, and in the midst of these foci of chronic hepatization of slight vascularity, are found foci of acute lobular pneumonia rich in sanguineous vessels."

This represents, moreover, the state of the question in 1843, in which I found nearly a complete blank for microscopic observations, and it must be admitted that it certainly was an advance to offer at that time these descriptions in total oppo-

sition to the two reigning opinions, that of the amorphous character, and that of the purulent origin of true tubercle. My principal object, at the epoch, was to demonstrate the organized and cellular nature of true tubercle, and the difference between these cells and those of pus.

Even to this day, I am reproached, first in Germany and later in France, with having regarded these cells as the specific element of tubercle. If such was my interpretation, it was more than twenty years ago, and it has been likewise a considerable number of years since I have professed the conviction that the microscopic elements of tubercle were not the essential part of it, nor even the specific cell. I ask indulgence from no one, and if any one will do me the honor to quote my observations, I have the right to exact that he should be familiar with them, and that he should not assume an obsolete point of departure as fixed and in force with me to-day, when it is so easy to bring proof to the contrary. Each year, and especially since 1856, I have pronounced against the specific character of the cellular elements of tubercle. Let it suffice for me to quote two additional passages from my works, which I believe decisive and irrefutable in this relation:

I. I state in my Pathological Anatomy: * "If I recognize specific elements as the anatomico pathological diagnostic of tubercle, far be from me the thought that these little cells enclose the essence of tubercle and constitute its specific elements. The discussion between my adversaries and me would only involve a difference of opinion of the value of these elements as means of microscopical diagnosis."

II. In 1858,† I declared in the Medical Journal (Nebdomadaire) of Vienna, that morbid products, altogether different from tubercles, exhibited the same little cells, and could not be distinguished from tubercle by the microscope, and upon the occasion of a case of glanders, I pointed out, as microscopically almost identical with tubercle, the little tumors, not

* Anatomie Pathologique, tome 1, page 668.

† Weimer Medicinische Wochenschrift. Jahrgang 111. Page 703.

yet suppurated, of glanders, and recent gummy syphilitic tumors. I pointed out as the cause of this microscopic similarity a similar mode of formation anatomically. I add that this resemblance of three products so profoundly different in pathology, should furnish a new proof that we should judge a disease from an assemblage of all the characters, and not from an isolated series of signs. I terminated these reflections by remarking that they proved in a very clear and concise manner that in pathological anatomy and in pathology, the microscope might be a useful and faithful servant, but should never become the lord and master. If, after these citations, any one should still apply to me the reproach of sustaining the microscopic specificity of tubercle, it is clear that he expresses by it his own criticism and not mine.

The passage of the cell of the connective tissue in process of proliferation towards tubercle, may be well studied especially upon serous membranes. It is not rare to see there, in the neighborhood of tubercle, disseminated groups of these cells in process of hyperplasia, and they will be found also throughout their progress up to the masses which form the granulations. Moreover, it appears to me more and more probable, that other cells than those of a connective tissue may also give origin to tubercle corpuscles. In the case of miliary granulations, some of them are often seen, with a good lens, much smaller, almost microscopic. It is in the summit of the lungs that their number is the most considerable, whether they be isolated or in groups. With some care, one may see not unfrequently, granulations in the tracheo-bronchial mucous membrane. They are ordinarily yellowish. I have here seen no semi-transparency.

Besides the granulations, there are likewise found in the summits of the lungs, sometimes little inflammatory infiltrations, lobular or a little more extensive grayish or semi-transparent, or little yellowish foci of true disseminated pneumonia foci, either granular or lobular, compact or already softened at the centre, even to pisiform cavities of the volume of a nut or even greater. Even in some cases of acute disease

of the lung, with every appearance of true tuberculization; there have been found nothing else than disseminated and confluent pneumonia foci.

If we thus perceive new points of contact between disseminated chronic pneumonia and acute tuberculization multiplied, another fact more important still appears to dominate, so to speak, this one. In the great majority of autopsies of acute tuberculous affections, there are found old foci of disease; amongst these by far the smaller number consist of old tuberculous granulations truly healed, shriveled, surrounded by black pigment. More frequently, on the contrary, there are found in the pulmonary summits old, yellowish pneumonic foci, from the smallest size up to that of a pea or of a bean, mingled with much pigment and callous, and apparently cicatricial connective tissue.

At other times there are found old, yellowish pneumonic foci, which have preceded the appearance of the tubercles by weeks or months. In other cases still, and quite frequent likewise, extensive tuberculous cavities with irregular walls, sinuous, enclose a purulent or muco-purulent detritus, co-existent with the recent tubercles of acute character, as evidence of the ulcerative pneumonia anterior to the granulations. Lastly, the bronchial glands, in subjects who have succumbed to acute tuberculosis, often enclose an old, yellowish infiltration still rich in cells, or a chalky deposit or true stony concretions. All these conditions may be combined in these different modes. I have avoided up to this time giving statistical statements of recorded facts, and reserving these data for a voluminous work upon chronic pneumonia and pulmonary tubercles, upon which I have been for a long time engaged. Nevertheless, I can not resist the temptation of communicating here the following statistical statement:

Without reckoning the more recent facts, not yet analyzed, I possess sixty-six personal observations, with autopsies of acute tuberculization, free or associated therewith by many points of contact. Eleven times only, or in sixteen per cent. nearly, there existed only three tuberculous granulations

without trace of old deposits, but it is possible that some may have escaped my notice, since formerly I did not attach nearly so much importance to this coincidence as at present. Six times there were acute tubercles combined with recent disseminated pneumonic foci; once there was general acute tuberculization, the lungs not being involved. There remain but forty-eight cases, or about seventy-five per cent. in which the old foci existed; four times there were tuberculous granulations alone, and in all the other cases pneumonic foci, cavities and old infiltrations of bronchial glands. It is very natural to seek in this coincidence the relation of cause and effect, and just as in disseminated chronic pneumonia, complicated with tubercles, these are consecutive, so likewise acute tuberculization is, in a sufficiently large majority of cases, consecutive to anterior pneumonia foci. We are struck with this other fact that acute tuberculization has been preceded by anterior miliary tubercle, infinitely more rarely than by inflammatory foci.

Another fact under our observation comes to the aid of the influence of prolonged anterior inflammatory process upon the production of tubercles. There are two of our observations in which a chronic purulent pleuritic effusion preceded, and probably occasioned, an acute consecutive pulmonary tuberculous affection.

Let us observe, in passing, that the four cases of old healed tuberculous granulations are evidence in favor of the curability of acute tuberculization, and serve to corroborate my diagnosis in two cases, in which I saw patients exhibiting every evidence of acute tuberculization of the lungs, gradually restored to health.

As to the seat of these tuberculous granulations, to judge by the naked eye, the interstitial tissue, the air cells, the bronchial ramifications, the subpleural tissue, and the pleura appear to be attacked. It is especially important to fix their point of departure and origin. In the pia mater this takes place along the vessels, and in the lymphatic fluid, which surrounds the arterioles. According to Virchow, it is less the vessels than

the fundamental tissue of organs which would give origin to tubercles. Lelleyer has observed the same in the non vascular organs in the corpuscles of Pacchioni. My histogenetic investigations have not, thus far, led me to satisfactory results; however, I desire henceforward to put myself on the defensive against every exclusive theory upon this subject. Colberg, in his excellent *investigations into the formation of tubercles*, admits that at a later epoch, the cellular tissue and the sanguineous vessels are effected with tubercular proliferation, just as alveolar inflammation originally epithelial may involve the interstitial tissue and the blood-vessels; but he indicates the cells of the capillary blood-vessel as the constant and exclusive point of departure of true tubercle.

I do not question the accuracy of these observations; whilst I can not yet decide upon so exclusive a genesis of tubercle by the capillary cells alone. We see in the heart the vascular structure in the endocardium with all its layers, a powerful muscular mass, to which is added the apparatus of a force pump of great power; then we perceive the elastic and fibro-cellular elements of the arteries diminish perceptibly in the veins.

Lastly, in the capillary vessels there remains no more than a single membrane, the internal epithelial tunic.

This important fact has been demonstrated in a certain manner by the beautiful investigations of Dr. Auerbach (of Breslau) and he calls these cells — which, reunited, form the capillary tube — perithelia; it is clear that these cells placed together and reunited, in order to form in their continuity a smooth and continuous tube of uniform calibre, could not become the seat of a true proliferation unless the capillary vessel might disappear; the blood would find itself then in the lacunæ, in place of circulating in the canals. Then the proliferation could only originate from the nuclei of these perithelial cells, and here especially would the capillary ruptures be frequent in consequence of this hyperplasia.

I have even, during a long scientific career, willingly conceded that theoretical objections ought to yield to observation,

especially emanating from a source so good. In admitting, then, that the perithelia of the capillary vessels serve as an essential point of departure for tubercle, we will with difficulty comprehend that these cells having so great an affinity to epithelia, these latter should be excluded from all participation in the tubercular endogenesis. I would add, that in my experiments, pulmonary tubercles, established in animals by inoculation of human tubercles, have appeared to have especially for their base cells very like epithelia.

On the other hand, I admit likewise willingly that even the yellow alveolar and epithelial miliary granulations of the lungs are completely different from true tubercles, and I have been able, in miliary and lobular disseminated pneumonia, without subacute tubercles, to follow all the phases of alveolar epithelial proliferation with the most extensive inflammatory foci in which the yellow infiltration was combined with diffuse gemmation of conjunctive tissue, colored by an abundant pigment, and in one case, which at other times would have been assimilated to acute tuberculization, I have seen these confluent foci as large as an apple, and even, in one of the lobes, equaling two thirds of its contents.

The pulmonary tissue around true granular tubercles appears very often entirely healthy, even anaemic, in consequence of a species of compensatory emphysema. At other times one finds around all its phases a simple hyperæmia, with alveolar collapse, or even little inflammatory infiltrations. Moreover, there is perceptible in the infero-posterior portions of the lungs, quite frequently, carification and emphysema upon the pulmonary borders, as well as in the anterior and superior parts. Pleuritic adhesions are frequent, and the pleura offers, besides the microscopic granulations, groups of fusiform conjunctive cells in process of proliferation, and likewise little circumscribed thickenings of the sub-pleural tissue, exhibiting in an especial manner the appearance of drops of wax. These, then, are the irregular points of cellular multiplication, as in the inflammation, accompanying true tubercle.

In one-fourth of the cases, I have found pleuritic effusion

from half a quart to a quart and a half of serous or sero-purulent fluid.

In two cases in which tuberculous granulations were developed subsequently to the pleuritic effusion, this latter, chronic and purulent, has appeared to be the point of departure. A fact which corroborates this view of the question has been communicated to me recently by Dr. Ebstein, the distinguished pathological prosecutor of the hospital of Breslau. A woman suffering from organic disease of the heart with very serious mitral insufficiency, was attacked by caries of the femur with abundant and prolonged suppuration, and fell a victim to acute tuberculization of the lungs, a disease most rare in the course of an organic disease of the heart. Legendre,* in reference to tuberculous meningitis, reports that, in this disease, twenty-seven out of twenty-eight cases exhibited very numerous tuberculous granulations; in twenty-four cases a tuberculous infiltration much older, extensive and yellowish existed in the bronchial glands, as has occurred hitherto under our observation, old foci having preceded without having occasioned, by infection, acute tuberculous disease. I have been struck with the relative frequency of granulations of the pericardium with acute pericarditis in the course of acute tuberculosis. The heart ordinarily encloses clots, some soft, others fibrinous. Obstruction of the large veins is rare, I have observed it in the crural and in the jugular. Tuberculous meningitis in acute tuberculization is much more frequently found in the adult, according to my observation, than is generally believed. It is, as during infancy, accompanied by internal hydrocephalus, by plastic meningitis of the base and sometimes by more voluminous yellow tubercles of the brain.

Tubercles are rare in the stomach, more frequent in the small intestine, which may nevertheless exhibit non tuberculous ulcers.

As in infectious diseases, the intestinal glands and the spleen are often perceptibly tumified, even without trace of

* *Recherches sur quelque maladies de l'enfance*, Paris, 1846, p. 12.

tubercles. The mesenteric and retro-peritoneal lymphatic glands have been, under my observation, quite frequently the seat of old yellow tuberculiform infiltrations long anterior to the acute tuberculous affection. The peritoneum is frequently the seat of true tubercles, with or without peritonitis, but there are found here likewise simple cellular masses and granulations, more decidedly inflammatory. Colberg has determined very clearly in the epiploon likewise the formation of tubercles by hyperplasia of the nuclei of the capillary vessels.

In acute tuberculosis the liver quite frequently encloses granulations, and moreover many very small, which can be determined by examination with a lens. No one has better described their formation than E. Wagner.* According to him, the hepatic cells are at first seen interrupted at intervals by masses of nuclei, sometimes indeed quite separated by microscopic tubercles. The nuclei of the tubercles take their origin in the cells of the interstitial connective tissue, or from the external tunic of the hepatic vessels, or finally from the nuclei of the investment of the hepatic cells, which indeed play the principal part in their formation.

The multiplication of these nuclei takes place very rapidly, partly by division, partly by new formation, as this author still admits, although it is perhaps at this time generally denied. Moreover, men of the highest merit, like Robin and Broca, admit it likewise, and I confess that whilst admitting cellular division and endogenesis as the principal sources of their pathological formation, it is impossible, notwithstanding the most attentive study, always to arrive at the determination of this mode of formation of morbid products. Further, if cells can be formed freely by endogenesis on the interior of other cells, I see no reason why the same phenomena might not occur outside of cellular membranes by a species of exogenesis. Besides it is better here, as well as for generation generally, to admit, wherever generic observation fails, an unknown genesis in addition to that by proliferation, and that

* Dir tuberkulose der leber (Archerder Heilkunde, von Roser, Wunderlich, eter.)

by endogenesis, as to make use, without sufficient proof, of the term spontaneous generation.

The spleen, moreover, whilst it is often diseased in acute tuberculosis without granular deposits, still quite frequently contains true miliary tubercles.

The same is true of the kidneys, in which, however, tubercles, still very small, have ordinarily a yellow color. Parenchymatous nephritis is rare in the disease now under consideration.

In cases of complication of acute tubercle with those of the testicle, which I have observed, this latter organ contains them ordinarily much older, and still more frequently infiltrations of a yellowish appearance and inflammatory origin, than granulations.

I have likewise, also, observed several cases in which acute pulmonary tuberculization supervened very rapidly in the course of an old chronic tuberculous, orchitis, or epididymitis.

The thyroid gland has presented to me several times true tubercles. In Switzerland I have observed all the forms of goitre amongst patients who had sunk under tuberculous disease, and I cannot comprehend how any one can admit an antagonism between goitre and tuberculosis. I terminate this sketch of true tubercle by insisting upon the fact, that it is almost always multiple, not only in one but in a certain number of organs, multiplicity being so much the more generalized as the subject is young and approximating infancy.

STRANGULATED INGUINAL HERNIA AT NINE WEEKS OF AGE.

BY CURTIS J. FENN, M.D., CHICAGO.

THE little subject was born of young and healthy parents, and began immediately to thrive upon its mother's milk. It cried a good deal at times, and had occasional diarrhoea, but of easy control. It was finally taken to the country, in the

vicinity of Blue Island, with benefit; on returning at the end of a fortnight it seemed to have more than ordinary promise. The mother carried it constantly on her lap, so that no direct injury could have happened to it. The night following its return it suffered with the colic, as the parents thought. Nothing gave it ease. Its cries became distressing, and continued with but slight intermissions. In the morning a tumor was discovered in the scrotum.

I first saw the case at 8, A.M. A fine, chubby boy. Its cries were pitiable in the extreme, between intervals of a few minutes sleep. It nursed; did not vomit; the abdomen was slightly tympanitic; the bowels had moved scantily morning and evening of the day before. The scrotum was edematous and red; a tumor existing within the right side, oval shaped, about an inch in its long diameter, and extending along the inguinal canal. The right testicle was not perceived; over the most prominent part the swelling was a shade darker. An attempt to reduce its size by manipulation was unsuccessful; no impulse was felt over the external abdominal ring. Hot clothes were applied, and camphorated tincture of opium given in sufficient quantity to produce continued sleep.

Three hours later the hardness of the tumor was diminished, but on crying again its size was increased. Persistent efforts were now made for its reduction by means of *Chloroform* and pressure, with partial success; 12 M. there was a small evacuation of the bowels; 1 P.M., the size of the tumor had been reduced one-half. There was by this time occasional vomiting of natural matter from the stomach. Digital compression was continued through the whole afternoon. The tumor was further diminished in size, but became harder, the hardness extending up the line of the cord. The child lay profoundly sleeping the rest of the day. In the night its cries became incessant. *Paregoric* in large doses failed to quiet.

Early the second day prostration was marked. The shade of discoloration was deeper, and the tumefaction greater. It no longer took the breast. Green matters were sometimes

vomited. The features were pale and sunken, and profound sleep had come again to the child's relief. 11 A.M. Prof. Gunn operated for the strangulation. Through an incision not more than an inch and a quarter long he found a deeply purple knuckle of intestine, filled with hardened faeces. He opened the sack, slightly enlarged the internal ring, inserted it within the abdomen, and closed the wound with three delicate sutures. The testicle was now in its proper place, appearing natural. No blood had been lost. A light compress was closely fitted, and the child placed on its back and allowed quiet. It was comfortable during the afternoon. Three or four movements of the bowels followed during the night, discharges green. At the same time it became very restless again. *Paregoric* was given freely.

In the morning of the third day it was quietly sleeping. Its skin was hot and dry. The wound was pale. Milk and wine were given through the day, and at night one-sixteenth of a grain of sulphate of morphia; afterward repeated.

In the morning of the fourth day it lay perfectly quiet; took nourishment as before. The wound looked healthy. In the afternoon slight convulsions were excited during a thunder storm, and continued with little intermission for several hours. Its extremities became cold and pulseless, its respiration almost imperceptible. It afterward revived, then gradually sank, and, about noon of the fifth day, died without a struggle.

The case illustrates the danger of strangulation in congenital hernia; the exhaustion attendant upon suffering, and the fatal policy of delaying an operation when it is to become necessary.

234 THIRTY-FIRST STREET, *August 26th, 1868.*

A COMPLETED HISTORY.

CHICAGO, *August 29th, 1868.*

To the Editor of the CHICAGO MEDICAL JOURNAL:

WILL you be so good, if possible, as to give room to the subjoined?

CASE OF ALBUMINURIA TREATED WITH NITRITE OF UREA.

History.—Dr. W— desired me to visit Mrs. —, in consultation with him, on the 2nd June ult., whose history was as follows:

Mrs. H—; aged 29; carpenter's wife; tall, nervous and cachectic; mother of four children, youngest 18 months old. She states that fifteen weeks ago she was seized with severe pain in the lower part of the back, and became very ill, when she called a physician, who told her she was suffering from an attack of intermittent fever; and subsequently, that the more persisting pain in the back was the result of rheumatism. Her feet now began to swell, which extended to her legs, thighs and body. Her breathing became embarrassed, compelling her to be supported upright in bed. She became so weak that she required to be lifted from side to side in bed. About four weeks after the onset of her illness, an abscess broke over the pained part in the lower region of her back, and discharged a large quantity of matter. It has continued alternately to heal, re-open and discharge ever since. The swelling in her chest has diminished of late, but her thighs, legs and feet continued the same.

A short time ago her medical attendant brought another physician to see her in consultation. Immediately after this, her husband solicited Dr. W— to attend her.

The foregoing "case" is notably interesting; but as the "history" given hardly covers the "case," I venture to add a little to that "history."

Early in March last, I was requested to see the subject of the "case" whose "history," as written, I have quoted. She complained of febrile action during part of the day, with pain in back and limbs, and thirst, the balance of the day being passed in comparative comfort. The tongue being a little coated, I did not hesitate to pronounce and prescribe for an intermittent. Within two days thereafter, I was notified that she was suffering from pain in right arm. Whether right or wrong in the first diagnosis, upon seeing her now, an

onslaught of rheumatism was unhesitatingly pronounced. Perhaps, however, the case was one of "Nephritis." For three days, remedies availed but little, although *Morphine* obtained insensibility to a considerable extent, much to the delight of the patient, as neither head nor stomach suffered from sequences. About that time, however, the inflammation abandoned the arm almost absolutely, but not the patient, as the *right hip* was forthwith assailed with terrible vehemence. (Does this bilateral feature belong to nephritis?) Now followed a condition I never saw with any other patient. She absolutely refused to be lifted for any purpose whatever. The left limb being movable, though all motion of lower limbs was painful, cloths were adjusted, as well as those caring for her could adjust them, to absorb the urine which was voided at intervals, and for a time, painlessly. Dejection was attended to in the same manner. Two days after the hip was assailed, micturition was painfully performed, the pain being upward to the region behind the pubes. During the second day after, the bladder became painful; it ceased to contract upon its contents, and I was obliged to use the catheter and repeat the operation several times during the next three days, when, though painful, the bladder resumed its propulsive functions. The urine was considerable in quantity, strongly acid, without blood and without albumen. The patient resisted the earnest importunities of the husband to remove her to another bed; but the odor becoming intolerable, I ordered her removed whether she consented or not. It was then I discovered the bed was saturated with urine where the nates had rested. I entertained serious apprehensions that the skin had become poisoned by the absorption of urine, and blamed myself that she had not sooner been forced from her bed. My fears were well based. Several obstinate ulcers formed upon the nates and the region just above. Now it was that she began to make outcries about her *back* as well as her *hips*, and as the latter became less sensitive during the progress of the "case," her *back* alone seemed to be the centre of distress; and it is to be noted that, whenever

requested to point out the exact location of the pain, she invariably referred to the inflamed nates and region just above. The ulcers healed under the bountiful application of *Glycerine* continued for a fortnight, and followed, toward the last of the healing process, by an unguent. To relieve the buttocks, which had become exceedingly tender from pressure, as she could lie on neither side, I improvised a ring made of cotton batting, to place them in, the region of the kidneys receiving an unwonted pressure. This secured comparative comfort, though I anticipated evil from the circular compression. After the ulcers healed, there was tenderness, swelling and hardness of the region inflamed. During this time the thigh had become swollen, and the swelling extended to the foot in the course of a few days. Bloody urine was now observed for the first time, but disappeared without special interference, to recur after the dropsy became general, and again subside without special treatment. Urine was still somewhat acid, and now contained albumen, which increased steadily for some time, as did the alkalinity. The left foot now showed effusion, and the abdomen was distended. This did not become enormously distended as did the lower limbs. The face showed some puffiness, but not very considerable. The chest was also invaded, but gave no evidence of it by shortness of breathing till two months after the illness commenced. The hands were the last to become dropsical, and were least so of any part during my attendance. Nearly six weeks after she was confined to her bed, a large abscess ruptured just over the lower lumbar vertebræ. I confess to not having looked at the inflamed region for several days prior to the rupture, a piece of neglect not to be copied. After several days the discharge ceased, but the abscess re-formed within a fortnight, and I opened it, putting a tent in the orifice. The abscess soon ceased to discharge, but re-formed, and I opened it again just before I abandoned the case. A huge poultice was the dressing.

As might be supposed, the pulse ranged above a hundred during a whole month, and but little below that while under

my care, till toward the last, and then under the influence of *Veratrum*. In the earlier stages of the ailment the tongue became somewhat coated, and was redder than comported with safety. Before the abscess ruptured, her stomach became quite irritable, and for a few days I suspended all ingesta save aliment, and but little of that was taken. The dropsy then gained some headway. Soon, however, the irritation subsided, and the appetite became voracious. I indulged the demands of the palate and she overdid the thing, the stomach becoming intolerant of every thing. A few days of rest sufficed to restore the tone of the stomach; she ate with avidity and bore well the diuretics and cathartics now much needed to remove the effusion of the chest. They acted thoroughly, and the relief obtained was marked and permanent in the face, hands, chest and abdomen, though not complete when I abandoned the case. As the effusion diminished, a marked diminution of albumen was noticeable, and the urine slightly reddened litmus paper, but the acid reaction did not become decided while the case was mine.

I have neglected to say she had two attacks of what may be termed pleurodynia, after the chest was invaded by the effusion, the interval being several days, and *Morphine* was administered to relieve the pain, which it did effectually. She had but little headache throughout, but was much inclined to sleep after albuminuria was established; sometimes, 'tis true, under the influence of *Morphine*, but also, either from the toxic effect of urea, or from effusion within the cranium, or both.

Her strength was at no time as much diminished as might be supposed. She did some sewing and knitted several pairs of stockings during her illness, and I once found her at the table preparing vegetables for cooking.

When the arm was assailed, I put her upon the *Permanganate of Potassa* with negative results, and suspended it when the hips became involved, endeavoring then to saturate the system with *Citric acid*, lemons being allowed *ad libitum*. They finally disagreed with her. Indeed, the red tongue was

attributed to their agency. *Bicarbonate of soda* followed with negative results, unless it caused or increased the alkalinity of urine. From the commencement of the ulcerative process upon the nates, I kept her upon *Iron*, either the muriated tincture, or the phosphorated elixir, except when the stomach would tolerate nothing. Wine was used freely after debility ensued, and raw egg added to it three times a day till the egg became repugnant to her. *Quinine* was given liberally. Of that article she had a horror, as she was taking it when her arm was attacked, and she believed the *Quinine* produced the rheumatism. Her aliment I endeavored to have of the most nutritious kind. To relieve the dropsy, the changes were rung upon the diuretics, and to some extent upon the cathartics. Hydragogues, when breathing became difficult, were resorted to reluctantly, as I dreaded their effect upon the stomach; but the dyspnoea had to be relieved, so I took the chances, and won. It may be stated that peristaltic action of the bowels, during the most of the illness, was maintained with little encouraging success. The promptness with which the kidneys responded to the action of diuretics, without calling forth expressions of uneasiness from those organs, barred the presumption of the existence of active nephritis. Indeed, two weeks before I abandoned the case, I informed the husband of the probable recovery of his wife, provided granular degeneration of the kidney was not established. Of that, I told him time must determine, but I did not believe it existed. When I did abandon the case, the patient was vastly improved, save as to the abscess, and as I was firmly convinced it was connected with neither bone nor kidney, that it would finally and speedily close, I verily believed.

The prolonged illness of the patient abated no tittle of her amiability, and, having taken offence several times, finally, and unexpectedly to him, I told the husband he must get another physician, as I should not call again. This course, I was aware, left me open to just such a "history" as I have

quoted, but I took it deliberately, and am not disappointed over the "history of the case."

It is probable that nothing I did for the rheumatism itself was of any avail, nor the exhibition of opiates, which did attend sensibility. There may be some doubt as to the cause of the abscess. Such results do occasionally follow or accompany rheumatism; but I am strongly imbued with the idea that the circular compression of the ring, and the previous poisoning of the urine, had no little to do with it.

I do not think "the most remarkable feature (in the case) was the entire disappearance of albumen from the urine." Albuminous urine does occur, though rarely, in cases of rheumatic fever, and recoveries ensue, complete and permanent. Scarlet fever is not unusually followed by albuminuria, the quantity of albumen being sometimes very great, and yet recoveries, also complete and permanent, are not unfrequent, as every practitioner of even limited experience, knows. The whole case may be considered remarkable on account of its grave complications. The pain in the bladder was a new feature to me, in such a connection, but my researches led me to the conclusion that the muscular coat of the bladder is also subject to inflammation of rheumatic character. The invasion of that coat was as interesting to me as was the existence of albuminuria; because neither occur frequently in attacks of rheumatism, and both are to be regarded as interesting complications because of that infrequency, and because they added to the severity and prolongation of the "case." But "the most remarkable feature" connected with the case, is, in my opinion, the ridiculously absurd inaccuracy of the "history" I have quoted, so far as the early condition of the patient is concerned. The writer seems to have reached his conclusions from the most striking feature of the case when he first saw it, to-wit: the albuminous deposit. For it is difficult to believe that the patient, or her friends, would have concealed the important facts which I have communicated, had a searching interrogation been instituted. These random "histories" go a great way toward rendering medical litera-

ture uncertain and obscure, and they ought not to be *perpetuated*.

The "case" quoted can be found on page 530 of your issue, under date of August 15th, current year.

A. A. DUNN, M.D.

FOREIGN CORRESPONDENCE.

LONDON, ENGLAND, *August 12th, 1868.*

MY DEAR DOCTOR: I have endeavored quite a number of times, since I last saw you, to find time to write you a few lines, and some for the JOURNAL, in accordance with your suggestions before I left Chicago, but I have been moving so constantly that I have found it almost impossible. I landed at Queenstown, Ireland, on the 16th of June, and visited Cork and the Killarney Lakes, after which I went to Dublin, where I spent about two weeks most delightfully. I met Stokes, Sr. and Jr., Wilde, Hamilton, Banks, Beatty, Mapother and others. I was shown the professional, as well as other sights of the city—was wined and dined by them, both in town and at their country places, and was most hospitably treated every where by them. I attended the commencement exercises of the Dublin University (Trinity College), and visited most of the medical schools and hospitals, of which I will try to write you more hereafter. From Dublin I went to Belfast and the Giant's Causeway, and then to Glasgow, having been "ticketed" on by my Dublin friends and consigned to Dr. Gardiner of the Glasgow University, Dr. Cowan and Dr. Buchanan. I had a very pleasant visit of a few days there, and saw much of professional interest. From there I went to Oban, on the west coast of Scotland, and crossed through the Highlands, and visited Lochs Lomond and Katrine, the Trossachs, and passed on through Stirling to Edinburgh, where I

met Sir James Simpson, Syme, Hughes, Bennett, Watson, and quite a number of the other notabilities. I went with Bennett to the Edinburgh University, and saw his dogs, on which he was making his experiments, which seem to say that our ideas of the action of *Mercury* have not been correct. I spent about two weeks there most agreeably, and just missed Dr. Freer and Dr. Chas. G. Smith, who had been there a few days before. From there I returned to Glasgow, and spent a few days more, and then went to Liverpool, and spent a couple of days in looking up the sanitary matters of that city, which are admirably conducted, and their system of public baths and wash-houses is a credit to any city. I have examined that matter closely in all the cities I have visited, and Liverpool compares most favorably so far as I have seen. From there I went to Chester, to see a fair specimen of an old walled city. From there I came to London, and in the three weeks I spent here, I met Sir Wm. Ferguson, Erichsen, Bowman, Critchett, Solly, Spencer, Wells, Hutchinson, Sibson, Lawson, and saw most of them operate. I have visited Guy's, St. Bartholomew's, London, Charing Cross, Royal Ophthalmic, Westminster Ophthalmic, Southwark Ophthalmic, Royal Orthopaedic, and quite a number of other hospitals, most of which have colleges, as you know, connected with them. I have made notes of most of the matters of interest, and if I can find time I will try soon to put some of them in shape for your journal. After making quite good use of the time I spent here, I went to Oxford to attend the meeting of the British Medical Association, to which I was a delegate, and which met on the 4th inst. Of this I will send you, herewith, a brief account, and I have sent, to Dr. Lyman, papers containing an account of most of the general order of the proceedings, and some of the works. I desire to preserve them, but if you desire to consult any of them he will place them at your disposal for the time being.

I start for Paris to-morrow, where I shall remain a short time, and be in Heidelberg on the 3rd, 4th and 5th of September at the Congress of the Ophthalmia men of Europe,

where, it is expected, Graefe, Donders, Stellwag, Arlt, Critchett and others will be. After that I expect to go to Berlin, Dresden and Vienna, and if, in the meantime, I can catch a few spare hours, I will try to place the result of them at your disposal. I should be glad to hear from you at any time. Address me—Care of Norton & Co., Bankers, 14 Rue Auber, Paris. They will forward any letters for me. Hoping to see you in a few months, and with kind remembrances to all friends, I remain very truly yours,

SAMUEL J. JONES.

The thirty-sixth annual meeting of the British Medical Association occurred at Oxford, on the 4th of August, and was organized by Professor Stokes, of Trinity College, Dublin, the President of the Association for the past year.

In accordance with the custom of the Association, after organizing the meeting, the President delivers a valedictory address and resigns the chair to the President elect, who delivers an inaugural address, which duty this year devolved upon Professor Ackland of the University of Oxford. This generally completes the work of the first day. The next day generally begins the real work of the meeting. The arrangements for the general meetings of the entire Association, and for the different sections of medicine, surgery, obstetrics, etc., are made, and assignment is made to each of its proper share of work. The delegates from other Medical Associations are then admitted. The American Medical Association was this year represented by Dr. S. D. Gross and Dr. H. E. Goodman, of Philadelphia. Dr. Fordyce Barker, of New York, and Dr. S. J. Jones, of Chicago, as delegates to the Oxford Meeting.

During the general meetings of the Association addresses were delivered by Professor Rolleston, of the University of Oxford, on Physiology ; by Dr. Gull, of London, on Medicine, its present status, etc. ; by Professor Haughton of Trinity College, Dublin, "Sources of vital and mechanical force derived from food, and its influence on medical practice," and by Professor Bennett, of the Edinburgh University, on the

action of mercury. The latter address was accompanied by tables showing the result of a series of experiments (upon dogs, in which biliary fistula had been made, under Professor Bennett's direction), which are adduced as evidence that mercury does not increase the secretion of bile. The recognized position of the author of the address, the apparent care with which the experiments were conducted, and the importance of the questions entitle the subject to consideration, and lead us to hope that something satisfactory may result from the experiments to be continued.

The report of the Joint Committee of the British Medical and Social Science Associations on Public Medicine, appointed last year, was presented in the general meeting, and various subjects bearing upon the advancement of the medical profession, and regarding sanitary science were considered. In medical education, the same difficulties are experienced, and the same questions agitate the teachers, and interest the profession at large, in Great Britain, that have received so much attention in the United States, as to how the standard shall be elevated, and the proper protection secured for both practitioner and the public. Much is hoped for here from the establishment of the British Council of Medical Education, the only legal Medical Association of Great Britain.

The President's soiree was given at the Museum of the University, and afforded all an opportunity of examining that, and the "Annual Museum" of the Medical Association, which was inaugurated this year, and opened for the session in the building of the University Museum. It is a beginning of what promises to be an interesting feature of the annual meetings, and is one worthy of the consideration of the American Medical Association. The design is to show the advancement made in the profession from year to year by annually collecting together during the session, wherever it may occur, of new surgical instruments, interesting pathological specimens, valuable new medical works, etc., etc. Prominent among the latter, this year, were the works issued from the Surgeon General's office of the U. S. Army, and the

flattering and frequent allusions made during the meeting to the American contributions to medicine and surgery were very gratifying. Before adjournment, the appointment of a deputation to attend the next meeting of the American Medical Association was authorized—their first delegates to that association.

The work of the sections is arranged much in the same manner as that of the American Association, the organization of the two associations being almost identical. A printed daily bulletin is issued here, stating the work of the different sections for the day, in addition to matters of general interest, which, if imitated by our own association, would prove a convenience to the members.

In the surgical section, much of interest was presented, though comparatively little that was new. The subject of torsion as a haemostatic means received considerable attention. The results of quite extended experiments were given, and seemed to indicate that in medium and small size arteries it is reliable and valuable, but could scarcely be considered so in large vessels. Acupressure was not specially considered. On the subject of the value of carbolic acid in surgery, much difference of opinion was manifested as to the range of its applicability.

One of the most ingenious apparatuses presented at the meeting was by Dr. Adams, of Maidstone, England. It is an instrument which he has devised for measuring the field of vision, which seems to be very reliable, and if so, will prove a valuable aid to ophthalmic surgeons, in supplying what has long been needed. It consists of a glass hemisphere, supported on an iron rod, with a slide to accommodate it to the height of the patient's eye. The eye of the surgeon is opposite that of the patient, who can thus see if the patient changes his eye in marking the field of vision, which is done by noting with a piece of soap on the glass hemisphere the limit of vision. The hemisphere is divided into meridians of longitude and parallels of latitude, and by having a similar diagram drawn on a small scale on paper, a convenient mode of recording the case for future use is afforded.

Many other matters of professional interest were presented in the different sections, but comparatively little that was new. Before adjourning, the annual elections took place, and Leeds, England, was decided upon for the next meeting, and in compliance with a rule of the Association, which requires that the President for the following year shall be from the district in which the meeting is to be held, Dr. Chadwick, of Leeds, was chosen as the presiding officer for the next term.

PHILADELPHIA CORRESPONDENCE.

PHILADELPHIA, Sept. 18, 1868.

Editor CHICAGO MEDICAL JOURNAL:

The tendency towards *speciality* in our profession is daily increasing. Young men, of enlarged views and intelligent minds, are graduated from our colleges, and enter upon a *special* field of work at once. Notwithstanding the ridicule that has been thrown out, or *attempted* to be thrown out, against this class of our profession, it is, nevertheless, an indisputable and recognized fact that the idea is becoming a fashionable one.

Fashion is just as much a tyrant in medicine as it is in the tailor establishment of our modern dandy, or the elegant dress emporium of our *elite* females. And this is not new or utopian. Several years ago, the late Professor Green, of New York, astounded the world by his proclamation of his treatment for throat and even chest affections. Immediately throat affections became *fashionable*, and thousands of mouths were opened to have the *swab* pushed down the throat. Louis XIV. was a sufferer with anal fistula, and in France this disease became at once so fashionable that surgeons were busy with cutting for this alone; "those who had only a *small draining* run immediately, and *turned up their posteriors*." In 1840 and '41, when Dupuytren's operation for relaxation of the sphincter ani was in vogue, it became popular

in this country, especially in New York, where *every thing* is in excess, and it is said the result was that "New York anuses looked like *ginlet holes in a piece of pork.*" And fashion still holds a powerful sway in our profession, but whilst we are embracing specialities more largely than heretofore, we are doing so with more discretion and intelligence. There is, too, that cordial and genial feeling entertained by the profession, as a class, towards specialists which is so impressively becoming to the fraternity. And this feeling is growing warmer and more extended every day. My object in these few prefatory remarks is to bring into notice that speciality which is becoming so popular among us now, and which, perhaps, of all others, is the object of the most uncharitable remark. I mean that of uterine diseases. Dr. Buck, of New Hampshire, two years ago, in an address before the medical society of that State, devotes about two pages in the printed matter, to the ridicule of these diseases. My purpose is to occupy a few pages of your journal in a series of two or three letters, illustrating, by cases, accurately and concisely given, the great prevalence of uterine diseases, and the value and importance of devoting *special* attention to them. To show, if possible, that the "*raid* being made upon the uterus at this time" is in the hands of intelligence, the means of averting much distress, and relieving much suffering, and to show that this "*harmless, inoffensive* little organ, stowed away in a quiet place," when *roused*, is the means of wrecking life, making pleasure a burden, and arresting, to an alarming extent, the furtherance of the race. And if proper treatment in this direction is observed, and these results *can* occur, it is *good* that there are those who "mount a speculum."

In my next letter I shall notice uterine disease *in general*, its unprecedented prevalence, its causes and its tendency. In letters No. 3 and 4 some notes will be made of special uterine diseases, together with some remarks on their treatment. As far as I can, I shall illustrate my subject with interesting cases.

E. K. HUTCHINS.

EDITORIAL.

Circumstances, over which we had no control, have delayed the present number a few days. We shall be up to time again at our next issue. Owing to the pressure upon our space, foreign items are necessarily postponed until next number.

Attention is especially directed to the exhaustive essay on the pathogenesis of disseminated chronic pneumonia and of pulmonary tubercles, by PROF. LEBERT, now passing through our pages. The name of its illustrious author is sufficient to vouch for its entire reliability. The conclusion will be given within the subsequent or next ensuing issue. It alone, we feel warranted in saying, is worth more to the thinking practitioner, than a year's subscription price of the JOURNAL.

Atomizing Apparatus.

Codman & Shurtliff have furnished for experiment a specimen of their improved atomizing apparatus. It is fitted either for the purposes of local medication or refrigeration. A glass protecting funnel is added, which can be removed at pleasure, making the whole exceedingly compact and convenient. For sale by Bliss and Sharp, 144 Lake Street.

U. S. Marine Hospital at Chicago.

The report of the accomplished special agent and medical inspector of Marine Hospitals, W. D. STEWART, M.D., on the inspection of our Marine Hospital, is very complimentary to Surgeon Rogers, who has it in charge. This was to have been expected by all who know Dr. R. The only objection to him is he won't get married and thus perpetuate those like him.

Honorary Degrees.

When the Western and Nashville Journals get through their unwilling noddles the idea that HONORARY DEGREES have, from time immemorial, been conferred upon those who have especially distinguished themselves in medicine, as writers, discoverers or practitioners, it will be time enough to reply to their discreditable slurs upon certain gentlemen who have recently been selected as recipients of this honor by "a certain medical college." The fact of previous graduation or non-graduation, of course, has nothing to do with it.

Our Amiable Contemporary out West will receive suitable attention soon.

"*What's in a Name?*" An article under this heading is on file for insertion soon.

BOOKS RECEIVED.

CRIMINAL ABORTION: Its Nature, Its Treatment, and Its Law. By Horatio R. Storer, M.D., LL.B., etc., etc., and Franklin Fiske Heard. Boston: Little, Brown and Company. 1868. Pp. 215.

VESICO-VAGINAL FISTULA, From Parturition and Other Causes; With Cases of Recto-Vaginal Fistula. By Thomas Addis Emmet, M.D., Surgeon-in-chief of the New York State Woman's Hospital, etc., etc. New York: William Wood and Company. 1868. Pp. 250.

ON DISEASES PECULIAR TO WOMEN; Including Displacements of the Uterus. By Hugh L. Hodge, M.D., Emeritus Professor of Obstetrics and Diseases of Women and Children, in the University of Pennsylvania. *Nullius addictus jurare in verba magistri.* With Illustrations. Second Edition, revised and enlarged. Philadelphia: Henry C. Lea. 1868. Pp. 531.

ATLAS OF VENEREAL DISEASES. By A. Cullerier, Surgeon, etc., etc., Paris. Translated by Freeman J. Bumstead, M.D., Professor, etc. Part IV. Philadelphia: Henry C. Lea. 1868.

TRANSACTIONS of the Medical Society of the State of Pennsylvania. Nineteenth Annual Session. 1868.

TRANSACTIONS of the Indiana State Medical Society. Eighteenth Annual Session. 1868.

OVARIOTOMY: A Paper read before the Ohio Med. Soc., Session 1868. By Alex. Dunlap, A.M., M.D., Springfield, Ohio.

TRANSACTIONS of the American Dental Association. Fifth Annual Meeting, held in Chicago, July 25th to July 28th, inclusive, 1865; and Sixth Annual Meeting, held in Boston, July 31st to August 7th, inclusive, 1866. Boston: Alfred Mudge and Company, 34 School street. 1868. Pp. 511.

**CLINICAL LECTURES ON DISEASES OF THE EYE AND EAR,
AT THE CHICAGO CHARITABLE EYE AND
EAR INFIRMARY.**

The Sixth Course of Clinical Lectures at the Infirmary (16 East Pearson street), by Dr. E. L. Holmes, will commence October 5th, at half past one o'clock, P.M., and continue twenty weeks, on such days and at such hours as may be found most convenient to those who attend.

No Institution in the Northwest offers the student and practitioner superior opportunities for the clinical study of all forms of ophthalmic diseases and their medical and surgical treatment.

During the past year, more than 800 patients have received the benefits of the institution, of whom a large number required important surgical operations on the eye.

During the last course, there was an average daily attendance of 40 patients at the Infirmary.

Excellent opportunities will be afforded of studying each case, and comparing it with other cases. The abnormal condition of the various tissues of the eye will be illustrated, not only by the cases under treatment, but also by numerous plates, and by a large number of pathological specimens. Instruction will also be given in the use of the ophthalmoscope, and in the best modes of examining the ear.

Certificates of attendance will be given to the members of the class, at the close of the course.

Tickets for the course will be \$5.00 each. The fees will be devoted to the support of the Infirmary.